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ABSTRACT

An estimated 11 percent of American children live with at least one parent who abuses or is addicted to alcohol and/or drugs. Parental addiction is a significant factor in child abuse and neglect, with studies suggesting that 40 to 80 percent of families in the child welfare systems are affected by it. With appropriate treatment, many of these parents would be able to achieve recovery and take care of their children physically, emotionally, and financially. But treatment services--especially services that allow women to take their children into treatment with them--are relatively scarce. The Adoption and Safe Families Act of 1997 (ASFA) created new challenges for these families and for the systems serving them. ASFA's time limits on reunification services for families and an accelerated permanency planning process have increased the challenges facing families and the child welfare and treatment systems. The purpose of this report is to examine policy and practice issues affecting these systems and their clients. Specifically, this report: provides background on the problem of addiction in the child welfare system; discusses ASFA and its implications for families at risk for involvement or involved in the child welfare system because of parental addiction; presents case studies of how two localities are addressing addiction in their child welfare systems; and presents a model for addressing addiction among families involved in the child welfare system based on these case study findings. (Contains 32 references.) (GCP)

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SAFE & SOUND:

Models for Collaboration Between the Child Welfare & Addiction Treatment Systems

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The Legal Action Center is the only nonprofit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of alcohol and drug dependence, AIDS, or criminal records, and to advocate for sound policies in these areas.

The Arthur Liman Policy Institute enables the Center to expand its public policy work in the areas of addiction, HIV/AIDS, and criminal justice through a program of research, publication, and education.

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SAFE & SOUND:

Models for Collaboration Between the Child Welfare & Addiction Treatment Systems

April 2003

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Introduction

An estimated 11 percent of American children (8.3 million) live with at least one parent who abuses or is addicted to alcohol and/or drugs.[1] Parental addiction is a significant factor in child abuse and neglect, with studies suggesting that 40 to 80 percent of families in the child welfare system are affected by it.[2]

With appropriate treatment, many of these parents would be able to achieve recovery and take care of their children physically, emotionally, and financially. But treatment services – especially services that allow women to take their children into treatment with them – are relatively scarce. Between 13 and 16 million Americans need treatment for alcoholism and/or drug dependence in any given year, but only 3 million receive care.[3] The measured treatment gap for women is even larger.[4]

The Adoption and Safe Families Act of 1997[5] (ASFA) created new challenges for these families and for the systems serving them. ASFA's time limits on reunification services for families and accelerated permanency planning process (emphasizing faster adoption for children in foster care) have increased the challenges facing families and the child welfare and treatment systems.

The purpose of this report is to examine policy and practice issues affecting these systems and their clients. Specifically, this report:

- Provides background on the problem of addiction in the child welfare system;
- Discusses ASFA and its implications for families at risk for involvement or involved in the child welfare system because of parental addiction;
- Presents case studies of how two localities – Cook County, Illinois (state-administered), and Cuyahoga County, Ohio (county-administered) – are addressing addiction in their child welfare systems; and
- Presents a model for addressing addiction among families involved in the child welfare system based on these case study findings.

Addiction Among Families

Alcoholism and drug dependence are serious public health problems with large social and economic costs to families, communities, government, and society as a whole.

Addiction cost the United States an estimated $246 billion in 1992, including $28.75 billion in healthcare costs, $176.4 billion in lost productivity, and $40.5 billion in other costs (such as crime, welfare, and motor vehicle crashes).[6] These costs are borne primarily by the individuals affected and their families (44.7 percent) and the government (41.6 percent).[7]

An estimated 16.6 million Americans over the age of 12 were abusing or dependent on alcohol or drugs, representing 7.3 percent of the population in 2001.[8] The prevalence of alcohol and drug problems among parents is generally lower than for comparable adults

without children.[9] Still, an estimated 11 percent of American children (8.3 million) live with at least one parent who is addicted to alcohol, drugs, or both.[10]

The effects of parental addiction on children can be wide-ranging. The two main research findings are that children of parents with alcohol and drug problems have poorer developmental outcomes (physical, intellectual, social, and emotional) and are at higher risk for alcohol and drug problems than other children.[11]

Parental addiction is one of the most common reasons for entrance into the child welfare system. Most studies have estimated that parental addiction is a contributing problem for 40 to 80 percent of families involved in the child welfare system.[12]

These parents face significant personal barriers to recovery and stability. For example, many women with alcohol and drug problems also have histories of physical or sexual abuse, mental illness, and co-occurring physical illness, such as HIV/AIDS.

Systems barriers to success also exist. These barriers include different philosophical orientations of the addiction treatment and child welfare systems about expectations of outcomes, timetables, and relapse, as well as conflicting federal and state policy goals, overburdened child welfare agencies, and inadequate treatment availability (particularly for women with children).[13] In addition, legal and policy environments in these two systems may have an important effect on their ability to collaborate.

The Treatment System – Resources and Effectiveness

Treatment System for Families Involved in the Child Welfare System

Many families involved in the child welfare system have very low incomes[14] and do not have private health insurance. They need access to the publicly funded treatment system, whether through Medicaid or other federal and state programs.

The publicly funded treatment system cannot provide services to all who need it. According to the Substance Abuse and Mental Health Services Administration (SAMHSA) and Institute of Medicine (IOM), between 13 and 16 million Americans need treatment for alcoholism and/or drug dependence in any given year, but only 3 million receive care.[15] A 1997 study found that child welfare agencies could provide treatment to less than one-third of parents who needed it.[16]

Effectiveness of Alcohol and Drug Treatment for Families Involved in the Child Welfare System

Numerous studies have demonstrated that alcohol and drug treatment is effective and cost-effective, despite limitations in the availability of services. Treatment has been shown to reduce alcohol and drug use and lower health-care costs,[17] as well as increase family functioning.[18]

Studies have also shown that treatment is effective for families involved with the child welfare system:

- In Illinois, Project SAFE participants had a rate of recidivism (a new abuse or neglect complaint) of 6.3 percent, compared to a 21.4 percent recidivism rate among child welfare clients without an alcohol and drug problem and a 52.3 percent recidivism rate among clients with an alcohol and drug problem who did not receive treatment.[19]

- The National Treatment Improvement Evaluation Study (NTIES) found that the number of custodial parents who were afraid of losing custody of their children because of an alcohol or drug problem declined by 63 percent after treatment.[20]

- An Oregon study found that child welfare involvement dropped 50 percent (from 7.8 percent to 3.9) for individuals who completed treatment.[21]

- Among women served at PAR Village, a treatment program in St. Petersburg, Florida, nearly three-quarters regained custody of their children after treatment.[22]

Adoption and Safe Families Act (ASFA)

ASFA was created to address growing concern among policy makers about the size of the foster care population and the amount of time children were spending in foster care by moving children into permanent homes more quickly. ASFA represented a considerable shift in child welfare policy by firmly limiting the time allotted for reunification efforts and dictating that children's health and safety were "the paramount concern" in placement decisions.

Three provisions of ASFA have the most significant implications for parents with alcohol and drug problems who are or may become involved with the child welfare system.

Reasonable efforts. ASFA clarifies that when making "reasonable efforts" to preserve families before foster care placement and to reunify families, the child's "health and safety shall be the paramount concern."[23] States are not required to make reasonable efforts when a court has determined that the parent has:

- Subjected the child to aggravated circumstances (as defined by state law and including abandonment, sexual abuse, and chronic abuse);

- Committed murder, voluntarily manslaughter, or aided or abetted crimes such as murder/ manslaughter;

- Committed a felony assault resulting in serious bodily injury to the child or another child of the parent; or

- Had parental rights to a sibling involuntarily terminated.

Some states have also created exceptions to reasonable efforts when rights to another sibling have been terminated.

Suspending "reasonable efforts" in the case of previous involuntary termination of parental rights to a sibling will affect many parents with alcohol and drug problems. Because many parents struggle with addiction problems for years before entering treatment, they may have lost their parental rights to other children.

Later, they might become involved with the child welfare system when they are able to engage in treatment, or when they are finally matched with an appropriate treatment program. Under ASFA, however, the child welfare agency will not have to make efforts to provide them treatment because of the earlier termination. These parents risk both losing their child and their stability in recovery.

In states that provide the opportunity to challenge the use of an earlier termination as a basis for a current termination, parents and their advocates could enlist treatment staff in providing information to the court to show that provision of treatment services are in the best interests of the child and family.

The reasonable efforts decision can be a crucial one because if reasonable efforts are not made as a result of a determination by a court, then a permanency hearing must be held within 30 days after the determination that could result in the child being placed elsewhere.[24]

Permanency hearings. A permanency hearing is a court hearing to determine the plan for where and with whom the child will live. At the permanency hearing, the foster care or child welfare agency presents a plan about whether and when the child:

- Will return to the parent;
- Should be placed for adoption and the state will file a petition for termination of parental rights;
- Should be referred for legal guardianship; or
- Should be placed elsewhere.

ASFA changed the timing of permanency hearings:

- If the court determines that reasonable efforts to reunite the child with his or her family are not required, a permanency hearing must be held within 30 days of the finding. At the hearing, the court may direct the foster care agency to file a termination of parental rights petition immediately.
- In all other cases, a permanency hearing must occur within 12 months after the date the child entered care.

For families not afforded reasonable efforts to reunify, the permanency hearing may occur before they have been able to engage in treatment and/or had much time in treatment. Nonetheless, if they want to reunify with their child, they must submit whatever information they can about their treatment plans and progress. In addition, they might consider what alternative permanency plans would be acceptable to them while they continue treatment, such as placement with a relative or guardianship by a close friend.

When the permanency hearing occurs 12 months after placement, parents who are in

treatment have more data to provide the court. Treatment resources and services for parents should be identified at the start of the 12-month period so that by the time of the permanency hearing, all the services are in place and linked. Attorneys for parents and staff of treatment providers should be prepared for permanency hearings and decide ahead of time what information they can provide to the court.

Termination of parental rights (TPR). To prevent children from remaining in foster care for long periods of time, ASFA makes state child welfare and foster care agencies begin moving to achieve permanent placements for these children – and to terminate parental rights when that is warranted – in a timely way. With few exceptions, ASFA requires that a TPR petition must be initiated or joined by a state when (among others conditions):

- A child has been in foster care for 15 out of the most recent 22 months;
- A court has determined that a child is an abandoned infant under state law; or
- The parent has been convicted of one of the crimes that now provide a basis for a court to decide that no reasonable efforts are required to preserve or reunify a natural family.

The state or foster care agency is not required to file a TPR petition when:

- At the option of the state (or agency) the child is being cared for by a relative;
- A state agency documents a "compelling reason" why it would not be in the best interests of the child; or
- The state has not provided the child's family with the services the state deems necessary to the child's safe return home (in those cases where reasonable efforts to reunify a family are required).

The TPR timetables represent the greatest changes made by ASFA, with the most potential effect on parents in need of alcohol or drug treatment. The 15 out of 22 month "clock" requires child welfare caseworkers to begin planning for permanency as soon as a child is placed out of the home. Agencies must pay close attention to the deadlines and expect that states will pressure them to file TPR petitions in a timely way. Although agencies are required to file or join a TPR petition under these circumstances, they are not necessarily required to seek the actual termination of parental rights swiftly, nor are they required by the filing of the petition to end services to the family. In short, ASFA requires agencies to file for TPR, not to achieve TPR.

The law does provide some parents to qualify for exceptions to TPR, including because of:

- Compelling reasons. Ongoing parental participation in an alcohol or drug treatment program can be put forward as a compelling reason why TPR would not be in the best interests of a child, particularly when the parent and child are engaging in visitation and where the parent is able to plan for the child to return home. A

parent's participation in a parent-child program in treatment, especially in a residential setting, should be a compelling reason not to file a TPR.

- Services not provided. Parents and their advocates should review the service plan for what parents and the agency must do to achieve reunification. If treatment is one of the services to be provided but no treatment has been provided, or if treatment was delayed, the parent should not be penalized. Services also should be appropriate. A nonspecific referral or a phone number with no other information should not be considered a treatment referral.

Methodology

Since these new policies were likely to affect individuals and families with alcohol and drug problems, we studied how the child welfare and alcohol and drug treatment systems were responding.

The main goal of the project was to profile local collaboration – among the addiction treatment, child welfare, and family court systems – to implement ASFA in two counties that had recognized the role of parental addiction in the child welfare system. The two localities – Cuyahoga County, Ohio, and Cook County, Illinois – were selected to represent a county-administered and state-administered system, respectively.

Information for the project was collected in several ways:

- A literature review.
- Ongoing communication with state alcohol and drug treatment and child welfare agencies and with community-based providers of alcohol and drug treatment about ASFA implementation and its effects.
- Three-hour focus groups with staff from the child welfare, addiction treatment, and court systems in two sites: Cuyahoga County, Ohio (November 2001), and Cook County, Illinois (May 2002). Focus groups were professionally recorded and transcribed. The questionnaire guiding those discussions appears as Appendix B.

After the information was collected, it was synthesized into:

- A preliminary model for policies and practices for addressing addiction in the child welfare system that may help other states and counties trying to address this challenge.
- Two case studies examining the policies Cuyahoga County and Cook County had implemented to address addiction in the child welfare system, including perceived effects and continuing challenges.

Drafts of the model and the report were circulated to reviewers in the child welfare and alcohol and drug treatment systems in both counties. The final model and report incorporate their comments.

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Model for Addressing the Needs of Addicted Parents Involved in the Child Welfare System[1]

- *Collaborative Local Planning and Monitoring*
  - Include representatives from the child welfare agency, alcohol and drug agency, drug court, and treatment providers. Include representatives from other agencies, such as Temporary Assistance for Needy Families (TANF) and mental health, as appropriate.
  - Develop policies and practices jointly, including for screening, assessment, referral to treatment, monitoring, information sharing, and handling of relapse.
- *Identification of Funding Available for Needed Services*
  - What needs do clients have?
  - What funding streams can be used to address identified needs?
- *Information Sharing and Continuing Communication and Collaboration*
  - What information should the child welfare system share with the treatment system and vice versa?
  - What client protections are required under federal confidentiality and health information privacy laws?
- *Development of Criteria for Assessments*
  - What standard instruments should be used? Who should administer them?
- *Cross-Training*
  - What continuous training is needed to ensure existing and newly hired staff have access to it.
- *Evaluation of Partnership, Policies, and Practices*
  - Identify key process and outcome measures to be assessed.

[1] A more detailed version of this model appears in Appendix A.

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Case Study: Cuyahoga County, Ohio

Background

County Child Welfare System

The child welfare system in Cuyahoga County is overseen by the Department of Children and Family Services (DCFS), part of the county's health and human services agency.

Each month, an average of 6,000 children in the county are in foster care. One-third of those are in temporary custody, and one-quarter are in permanent custody.

According to DCFS staff, about 19,000 families are involved with the child welfare system each year. DCFS staff estimate that many of the more than 6,000 parents in those families need alcohol and drug treatment.

Currently, 4,600 children in the county are available for adoption. The number of adoptive placements has increased significantly (by 250 percent) since 1994. Most of the children available for adoption are African-American (60 percent), and half are between the ages of 11 and 15.

The main activities of DCFS include:

- A 24-hour hotline and intake department that investigates child abuse reports and refers children and fami55lies for services.
- A family services unit, which works with the juvenile court and local mental health agencies to reunite and preserve family units and provides protective supervision for children in their homes.
- A sex abuse unit, which investigates reported sexual abuse.
- A resources and placement services division, which conducts home studies of foster and adoptive parents, teaches independent living to older children in the county's custody, and handles family visitation, adoption, permanent custody, and supportive services.

START Program

DCFS is also the home of the Sobriety Treatment and Recovery Teams (START), a program begun in 1997 with funding from the Annie E. Casey Foundation in part to help parents with alcohol and drug problems involved in the child welfare system increase their participation in treatment and their abstinence from alcohol and drugs. The START program laid the groundwork for implementing ASFA in Cuyahoga County.

Under START, two units – staffed by teams of 10 social workers and 10 family advocates – were established in DCFS to address family addiction problems. START focuses on women in the county who deliver babies at five area hospitals with a positive drug toxicology screening. START child welfare staffing includes two child

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welfare supervisors, child welfare social workers, and child welfare advocates. The role of the advocates is to engage clients in treatment and other activities to help them achieve recovery and maintain or regain custody of their children. Local addiction treatment providers provide family-centered services to START clients, including extended family members and foster parents, friends, and other individuals involved with the family.

Each START team has a maximum of 15 cases to enable close client contact. In early phases of the case, the team sees the family at least once a week, including taking the client to treatment and/or 12-step meetings the first three times the client attends.

Close links between treatment providers and START workers are a key feature of the program. Monthly meetings between providers and supervisors and weekly contact between the team and the service providers are required during the client's treatment episode. In addition, all team members from the child welfare agency, including the advocates, received significant training in addiction treatment, case planning, and family preservation.

County Alcohol and Drug Treatment System

The county Alcohol and Drug Addiction Services (ADAS) Board is in charge of the county's alcohol and drug treatment system. ADAS receives funding from federal, state, and county sources (including $100,000 from DCFS, which supports Recovery Resources, a local women's treatment program).

The county treatment system includes more than 53 professional agencies operating more than 100 programs that handle alcohol, tobacco, and other drug prevention and treatment. The Board has service contracts with providers and plays a role in coordinating services.

In Fiscal Year (FY) 99, the system served 12,549 clients, who received a range of services, including detoxification, residential treatment, intensive outpatient services, and outpatient care. A total of 629 adults were referred to the treatment system from the child welfare system in FY 00.

In FY 99 , the majority of overall clients (61 percent) were men, and more than half were African-American (59 percent). One-third (33 percent) of those in the treatment system were between the ages of 22 and 35, with another 43 percent between the ages of 36 and 55.

Among women, most (65 percent) were African-American, and 45 percent were between the ages of 22 and 35. A total of 7 percent were pregnant when they entered treatment. Three-quarters (75 percent) had one, two, or three children. When they entered treatment, more than three-quarters (78 percent) were either unemployed or n otherwise not in the labor force. Almost half (44 percent) did not complete high school or have a GED.

In FY 99, crack cocaine, alcohol, and marijuana were the most prevalent substances for which people sought treatment, although drugs of abuse varied by gender. For men, the most common drug of choice was alcohol, followed by marijuana and crack cocaine; for women, crack cocaine was

most prevalent, followed by alcohol and marijuana. Most people entered public treatment that year through the criminal justice system (35 percent) and self-referral (35 percent).

County Drug Courts

Cuyahoga County has two drug courts that hear child welfare-related cases – a delinquency court for juveniles with drug charges and a family drug court. The delinquency court has been funded by the state, by a federal grant (that ended in September 2001), and through some local funding; the family drug court is funded by general county funds.

The county began requiring all START cases to be referred to family drug court in August 2001. The family drug court's docket, with a capacity of 45 cases, filled up quickly. Referred cases are heard within two weeks at the court and then weekly after that by the same magistrate. The county exercises protective custody in some of the family drug court cases; in others, the mother has custody, but under protective supervision.

Mothers of infants who test positive for drugs are required to appear before the same magistrate weekly and meet a series of requirements (such as six months of sobriety) before reunification can take place. The county defines "testing positive" as a child exposed to drugs in the second or third trimester, which includes testing positive prenatally or at birth. The goal of this definition was to identify women while they were still pregnant so they could enter treatment while pregnant and lower the risks to the developing fetus.

The court helps link parents to case management, drug treatment, and parenting classes – whatever is deemed necessary. DCFS social workers are required to report to the magistrate about treatment progress. While treatment providers may go to the hearings, time and resources often do not permit their attendance.

Ohio ASFA Law

Ohio's ASFA law, known as House Bill (HB) 484, went into effect in March 1999. The main provisions of the law include:

- The state must file a motion for termination of parental rights for children in temporary custody for 12 or more consecutive months in a 22-month period (shorter than the federal requirement of 15 out of 22 months).

- More listed exceptions to the reasonable efforts at family reunification standard than are included in the federal law, including an exception for repeated rejection (defined as two times) of or refusal to continue alcohol and drug treatment as required by a court order or a case plan for a child at risk of harm due to a caregiver's addiction.

- A significant focus on the effects of alcohol and drug abuse on families involved in the child welfare system, including provisions addressing coordination and sharing of information between state and local child welfare and addiction agencies and providers and a $4 million appropriation (over two years) for

addiction treatment services for the child welfare population.

- A requirement that the state Departments of Human Services (ODHS) and Alcohol and Drug Addiction Services (ODADAS) develop a joint report to State administrative and legislative officials focusing on needs assessment, treatment capacity, and the number of individuals who have received services.

The report, issued in December 2000, found:

- Consensus on the value of the intent of the legislation but less certainty about the results of implementation. Concerns focused on the lack of clarity of definitions, such as "treatment failure," and on achievement of success for a family within the mandated time frames.

- Both agencies thought that treatment services were generally accessible, given the priority created in the legislation, but had concerns about the displacement from treatment of other vulnerable populations.

- Mixed responses about whether the treatment system would experience an increase in referrals from the child welfare system.

- A need for holistic, family-centered intervention and treatment.

- A need for continuous cross-training of service providers in the addiction treatment, child welfare, and court systems.

Simultaneously, Ohio counties were implementing the Temporary Assistance for Needy Families (TANF) program, the new welfare block grant created by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[25] As part of implementation, ODHS and ODADAS signed an interagency agreement to build collaboration to address the needs of Ohio Work First (OWF) recipients with alcohol and drug problems, including those also involved in the child welfare system. The agreement, which went into effect in September 1998, included requirements for cross-training and technical assistance on alcohol and drug treatment services (including client confidentiality protections), county-specific expenditure reports documenting TANF expenditures for treatment services, timely assessment and treatment for OWF families, and joint care coordination.

In addition, through TANF implementation, Ohio created a Prevention, Retention, and Contingency (PRC) program with TANF funds. The PRC program is intended to divert families from OWF, resolve short-term difficulties, and keep working parents on the job and out of the welfare system, including through screening for alcohol and drug problems and referral to treatment. Before the state budget situation deteriorated, ODHS had invested more than $300 million of TANF funds in PRC.

ASFA Implementation in Cuyahoga County – Addressing Addiction

To start implementing HB 484 at the state level, ODADAS and ODHS worked on a plan to help guide local ADAS boards and child welfare agencies in developing county plans for providing treatment in a timely

fashion and monitoring client progress. Local agencies reviewed the plan and submitted comments to the state agencies.

Because of the START program, DCFS and local treatment providers had a history of collaboration. Building on START, planning for ASFA implementation was accomplished in the following multistage process.

Step #1 – Collaborative Local Policy Planning

Representatives of the state/county alcohol and drug agency, the state/county child welfare agency, and local treatment programs collaborated to design policies for addressing the needs of parents involved in the child welfare system with alcohol and drug problems within the frameworks of ASFA and START. Representatives of other systems – such as the mental health system and the family drug court – were also included, where appropriate.

Beginning discussions focused on the structure of each system, its statutory responsibilities and how they are operationalized, and its expectations of clients and partnering. Joint policy development focused on screening and assessment, referral to treatment, monitoring of treatment (including protocols for sharing of appropriate information while protecting client confidentiality), treatment placement criteria and standards, and protocols for handling decisions about relapse and its effects on child safety – all within the ASFA time limits.

Step #2 – Identification of Funding Available for Services

Each system identified funds that might be available to support needed services. Potential sources of funding explored included: Medicaid, TANF, IV-E, Substance Abuse Block Grant, Driver Intervention program, state or local levy, or general revenue funds. Matching requirements and other restrictions, flexibility and eligibility issues, and availability were taken into consideration.

Step #3 – Agreement on General Principles/Expectations/Practices

Agency representatives agreed on principles and expectations to help develop their working relationships. Areas addressed included referral protocols, elements of assessment and screening, responsibilities for criminal background checks, arrangements for drug testing, and guidelines governing sharing of information and confidentiality protections.

Step #4 – Development of Information Sharing Protocols

The child welfare agency agreed to give treatment providers the following information at the point of referral:

- Basic demographic data about the client, including name, Social Security number, date of birth, address, arrests/convictions (if known), marital status, number of children, names of household members, employment status, occupation, race, educational level, and insurance information.

- The reason for the referral, including specific relevant risk factors identified, court order, known facts (such as a DUI or DWI conviction), failure at a work activity site, and whether the client seemed motivated for treatment.

- An assessment of the safety risks to the children, including how the parent's or caregiver's alcohol or drug use is affecting the children, how it impairs their ability to care safely for the children, and whether the children have any special needs.

- The current placement of the children, such as at home, with a relative, or in foster care.

- Information about the legal time frame for reunification and permanency decisions.

Step #5 – Development of Criteria for Assessments

The agencies agreed that the assessment process should include:

- Information from family members, when possible and indicated, particularly given that treatment providers do not usually interview family members.

- Identification of the agency responsible for funding and conducting drug testing, when necessary.

- Alcohol and drug use and sobriety history, including criminal background information, driving record related to drinking or drug use, and known past participation in treatment.

- Self-report of the parent or caregiver about alcohol or drug use.

- Recommendations for treatment, based on agreed upon patient placement criteria.

Step #6 – Ongoing Communication Between Systems and Confidentiality Agreements

Agencies agreed that communication should include:

- Development of a standardized, written client-signed form, in keeping with the requirements of federal confidentiality law, that recognized the multiple agencies that would be sharing the information, including the child welfare, treatment, criminal/ juvenile justice, and TANF systems.

- Identification of automatic triggers for information sharing at such points as assessment, drug testing, progress reports of ongoing treatment, aftercare, no shows, and leaving treatment.

- Planning for participation in court proceedings. Each system agreed to maintain areas of expertise. For example, the child welfare system was responsible for providing information and recommendations about the risk to the child, while the alcohol and drug treatment system was responsible for reporting on treatment progress and the potential for treatment success within the applicable legal permanency time frame.

Within these steps, the ADAS board and DCFS also focused on:

- Increasing capacity in the child welfare system for alcohol and drug screening and assessment.

At the beginning of HB 484 implementation, the county spent $150,000 to purchase assessment services and added capacity to do as many as 14 assessments per day, with clinicians co-located at DCFS offices. As a result, within 24 hours of leaving the hospital after giving birth, women who had been identified as needing assessment received it and were connected with treatment quickly, where needed.

- Provision of cross-agency training and education.

Key issues addressed during cross-training included understanding the child welfare system, understanding the alcohol and drug treatment system, and the most effective approaches for making referrals into treatment.

- Restructuring of continuing care services for treatment clients.

Treatment providers restructured the continuing care components of their programs so clients, when possible, could appear in court with six months of negative urinalysis and demonstrate stable sobriety and increase the likelihood of reunifying with their children.

- Facilitating and improving interagency communication.

According to an evaluation of START, the program had improved communication between treatment providers and DCFS, particularly around relapse. The evaluation, conducted by the Research Triangle Institute, found that treatment providers had become more forthcoming about client relapse to DCFS social workers and that DCFS workers had become more flexible in response to relapse.

This foundation helped the ADAS board and county DCFS continue to work together on the communication necessary to implement HB 484. DCFS and treatment providers reported that they worked hard to build communication, including around controversial areas of the program, such as the six-month sobriety requirement.

Main Effects of HB 484

According to DCFS, the number of referrals into the child welfare system has remained relatively stable at 18,000 to 19,000 per year. The implementation of HB 484 did cause a backlog of cases at first, however, because 3,000 to 4,000 children in the existing caseload had already been in custody more than 12 out of the previous 22 months, the new limit.

In contrast, the population placed into permanent custody increased significantly. At one point, an estimated 800 children were involved in permanency filings by a complaint or motion that had not been heard. By 2001, the caseload had begun to decrease to pre-HB 484 numbers, or about 525 children involved in permanency filings and 2,000 children in permanent custody.

Parental rights terminations have increased, as have adoptions. On average, 1,500 children are in permanent custody awaiting adoption every month.

A key positive outcome of HB 484, according DCFS and treatment providers, is that the agency's involvement with at risk families begins earlier, often at the hospital after the birth. This means that the safety plans get made immediately, including changes in custody, if necessary. It also means that families get services more quickly.

Another positive outcome is that DCFS staff have learned more about how to motivate parents in families affected by addiction. DCFS staff say they have learned that court orders and threatening removal of children are not enough, but that families need treatment services, follow-up, and supportive services, in addition to service planning based on individual family needs.

Time limits, which are triggered when DCFS takes a child into custody, have caused significant challenges, however. According to both DCFS and treatment providers, the time limits do not give some families enough time to address their barriers to reunification. In fact, for some women, managing all of the requirements – complete treatment, maintain recovery for six months without a relapse, and get a job – may actually be a relapse trigger, increasing the likelihood that they will lose custody of their children permanently.

Continuing Challenges

Although child welfare officials and treatment providers generally believe that the process for addressing addiction in families involved in the child welfare system has improved, challenges remain. Continuing challenges raised in the focus group included:

- Stable funding for treatment services.

The child welfare system has not been a strong funding partner with the alcohol and drug treatment system because child welfare funding has primarily supported services for children, not adults. An added difficulty has been 10 percent across-the-board state budget cuts, which have particularly affected the ability of the family drug court to add to its caseload.

Providers also expressed concern about an inability to draw down funds allocated by HB 484 for treatment. In FY 99, the county had to return $218,000 of HB 484 funds to the state (out of a total allocated of $520,000) because they had not been spent.

- Continuing barriers to Medicaid funding for treatment.

Medicaid policies that disallow funding for services in an "Institution for Mental Diseases" (IMD) are problematic, according to providers. No federal reimbursement is available for services provided in an IMD, which includes residential alcohol and drug treatment programs with more than 16 treatment beds. This is an artificial damper on a key service modality for pregnant and parenting women.

Raising Medicaid match has also been a problem. According to providers, the county has indicated that it does not want to use county funding for Medicaid match because the program is a state and federal responsibility.

For some clients, loss of Medicaid eligibility has also been a barrier. Parents without dependent children (such as those whose children have been removed) are no longer eligible for Medicaid, so the program will not reimburse for services, even for those parents on track for reunification.

- Tracking referrals and funding.

The ADAS board has been working to implement a new statewide alcohol and drug MIS system, which has created difficulties in tracking treatment referrals and reporting information about clients served, funds used to serve them, and the effects, if any, of a lack of resources to serve them.

- Client relapse.

Under the law, parents are required to be drug- and alcohol-free for six months before reunification can take place. Yet most clients can be expected to relapse three times during the normal course of treatment. This is complicating reunification decisions at the 12-month time limit.

- Safe and sober housing for families.

The availability of safe and sober housing is a critical component to recovery. But some Section 8 voucher housing is located in drug-infested areas. This means that parents may do well for six or nine months, but a lack of appropriate support in that kind of environment makes relapse more likely. Part of the problem is that many landlords do not want to accept the vouchers. In some localities, a significant waiting list exists for Shelter Care Plus housing for individuals in recovery from addiction or with mental health problems.

- Availability of continuing care services for treatment clients.

More aftercare, employment, and reintegration services are needed, according to both DCFS and treatment providers. DCFS and providers reported that they had hoped that TANF would help support these services, but that has not happened.

- Addressing additional challenges facing the TANF population.

Among the parents still receiving TANF, about half cannot read or write and do not have their GED or good job skills. According to DCFS staff and treatment providers, TANF clients who lose custody of their children need the most time to reunify.

The combination of TANF and ASFA requirements can make the challenge even more difficult. When clients leave treatment, they have to find a job and a place to live and get settled, with six months of recovery behind them to reunify, with the clock ticking the whole time. It can be overwhelming for them and increase the likelihood of relapse.

- Electronic interagency communication.

According to DCFS staff and treatment providers, their inability to communicate electronically – including accessing each other's database and transferring information – has been problematic. Another concern is sharing information electronically and simultaneously protecting the confidentiality of clients across county agencies, courts, legal providers, and treatment providers.

Case Study: Cook County, Illinois

Background

State Child Welfare System

The Illinois Department of Children and Families Services (DCFS) is the lead agency for child welfare in the state. DCFS employs approximately 4,000 workers in its multiple subdivisions, including child protection, foster care and permanency services, clinical, and licensing services. DCFS also contracts with private child welfare agencies statewide for services to children and families.

Key components of the Illinois child welfare system include:

- A State Central Register in Springfield that maintains a 24-hour statewide hotline that citizens may call to report suspected abuse or neglect of a child.
- Child protective services to investigate reports of child abuse and neglect.
- Family maintenance services to ensure children are safe in their homes and communities.
- Substitute care and family reunification services to provide safe short-term care in capable, nurturing foster homes and when possible to quickly and safely reunify children with their families.
- Adoption and subsidized guardianship services for children when reunification is not possible.
- Support services to effectively and efficiently manage the state's child welfare system.

Research in Illinois indicates that 75 to 80 percent of all child welfare cases in the state involve parents with alcohol and drug problems.

State Alcohol and Drug Treatment System

The Illinois Office of Alcoholism and Substance Abuse (OASA), part of the Illinois Department of Human Services (DHS), is the lead state agency for alcohol and drug issues. OASA is responsible for developing, maintaining, monitoring, and evaluating a statewide treatment delivery system designed to provide screening, assessment, customer treatment matching, referral, intervention, treatment, and continuing care services for indigent individuals with alcohol and drug problems.

Services are provided by community-based treatment organizations contracted by OASA according to the needs of various communities and populations. Services are provided statewide, either directly within a county or by a multicounty service provider. In FY 00, the system provided approximately 125,602 services to clients.

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The state treatment system is supported by funding from a variety of sources. In FY 01, those sources included:

- $5.9 million in Medicaid funds, which primarily supported medically monitored detoxification, residential treatment for children, and services for women.
- $2.796 million in TANF funds for a client referral initiative to increase capacity for TANF recipients.
- $3.4 million for specialized treatment services for women victims of domestic violence.
- Categorical federal funding for treatment for women and children and residential programs for pregnant and parenting women with children.
- $9.2 million for an initiative to increase the amount and variety of treatment services to women in the criminal justice system.

Court System

Cook County does not have a family drug court. But many other courts – including a domestic violence court and a delinquency court – hear cases related to the effects of addiction in families. In Illinois, these courts are funded by the county (although judges are paid by the state).

The juvenile court has two presiding judges – one for juvenile justice cases and one for child protection cases. They are appointed by the Chief Judge of the Cook County Circuit Court. They can be expected to stay in their positions for longer than a year.

A long-range planning subcommittee of the Judges Advisory Committee has recently developed a curriculum to provide judges with two half days of basic training on addiction in the family. The curriculum is currently under consideration, as are the names of teachers who could do the training.

DCFS staff and treatment providers, however, have provided briefings to judicial staff. In addition, a contractor, hired by DCFS, is available on-site to provide alcohol and drug assessments and referrals at the juvenile court.

DCFS has worked closely with the juvenile court system to improve results for children who were wards of the court and wards of DCFS. Regular communication takes place about what needs to be added or changed. DCFS makes changes in the service system in a way that is compatible with or directly in response to the wishes of the court.

DCFS staff have also met with staff of other agencies involved in the criminal justice system, such as the public defender's office representing the parents, the Cook County Public Guardian staff representing the children, and private attorneys who are appointed when a conflict exists for the children and/or for the parents.

ASFA in Illinois

The Illinois Omnibus Permanency Initiative of 1997 (Public Acts 90-27 and 90-28) preceded ASFA's enactment at the federal level by several months. Adjustments were

made in 1998, as the second phase of the initiative, to bring it into compliance with ASFA.

Key provisions of the initiative include:

- A requirement that judges admonish parents of their responsibilities to cooperate with DCFS, comply with their service plans, and correct the conditions that resulted in their child's placement or risk termination of parental rights.

- A requirement that judges consider earlier termination of parents' rights for cases in which parental whereabouts are unknown or parents are found in default after receiving service and notice of proceedings.

- Clarification that when return home is not selected as a child's permanency goal, DCFS is not required to provide further reunification services and the State's Attorney is encouraged to proceed with termination of parental rights or to seek private guardianship for the child.

- Clarification that family reunification is not necessary in cases when it is not reasonable to do so, such as cases in which a child or sibling of a child was abandoned, tortured, or chronically abused.

- An emphasis on concurrent planning to attain permanency as soon as it becomes evident that the parent cannot or will not correct the conditions that resulted in the child's placement.

- A requirement that the first permanency hearing be held within 12 months of the date the child entered foster care, and every six months after that.

- Establishment of permanency goals and factors to consider when setting the permanency goal.

- A reduction in the time frame from 12 months to nine months after adjudication that a parent must make reasonable progress to correct the conditions which led to the removal of the child or reasonable progress toward the return of the child or risk termination of parental rights.

- Clarification that abandonment of a newborn infant in a hospital or other setting constitutes grounds to obtain termination of parental rights. Also, for children in DCFS custody, rights can be terminated when a parent who is incarcerated has shown a lack of interest in the child, or when the parent has been repeatedly incarcerated as a result of criminal conviction which prevents the parent from discharging parental responsibilities for the child.

- Establishing as grounds for termination of parental rights a finding that at birth the child's blood, urine, or meconium contained any amount of a controlled substance and that the biological mother of the child was the biological mother of at least one other child who was adjudicated a neglected minor, based upon the presence of a controlled substance at

birth, after which the biological mother had the opportunity to enroll and participate in a clinically appropriate alcohol and drug treatment program.

- A requirement that aftercare plans be developed and presented to the judge when the goal of return home is recommended. Provides that, when returning a child home, the court can order physical examinations by a licensed physician at periodic intervals.

- Power for DCFS to issue waivers for current foster parents and relative caregivers who are providing a safe, stable home environment, which will allow them to continue to be caregivers despite previous criminal activity, provided that the criminal activity occurred more than 10 years ago and the applicant previously disclosed the criminal activity.

Addressing Addiction in the Child Welfare System in Illinois and Cook County

Growing DCFS caseloads, particularly related to a rise in drug-exposed newborns, and provider and OASA interest in increasing gender-specific treatment capacity in the 1980s and 1990s motivated the treatment and child welfare systems to work together to address alcohol and drug problems in families involved in the child welfare system. The partnership has produced a range of programs for families affected by addiction that are involved in the child welfare system.

Two programs – Project SAFE and what providers and child welfare agencies call "the initiative" – form the foundation of the partnership. Project SAFE – a joint pilot program of DCFS and the Illinois Department of Alcoholism and Substance Abuse (OASA's predecessor agency) – was launched in 1986 to intervene with mothers with alcohol and drug problems who had a history of neglecting or abusing their children. Since its inception, Project SAFE has served more than 5,700 women across the state and expanded to 19 sites.

Project staff included outreach workers, clinical counselors and supervisors, program coordinators, and child care workers. A range of services was available to clients, including outreach, case management, treatment, child care, parenting training, linkage with support groups, continuing care (also known as aftercare), and relapse prevention.

Key findings from an outcome study – based on data collected from the first 105 women who participated in Project SAFE between July 1986 and June 1988 – include:[26]

- Project SAFE identified and provided treatment to a new population of addicted and neglectful mothers who in all likelihood would have remained undetected and untreated without the project. Over half of Project SAFE clients had no history of either addiction or psychiatric treatment.

- Project SAFE participants had high successful completion rates (81 percent) and high prognosis ratings

upon discharge (51 percent left with an excellent or good prognosis as rated by the treatment staff).

- Participants achieved a high degree of stabilization during early recovery and were able to extend their sobriety. Positive ratings achieved included abstinence from alcohol, involvement in Alcoholics Anonymous (AA) meetings, contact with AA sponsors, and avoidance of situations that would pose high risk of relapse.

- Through participation in Project SAFE, 30 of the 55 children who had been removed from their mothers were returned home, for a reunification rate of 54.5 percent. The reunification rate for children of mothers in the control group was 40 percent.

The OASA/DCFS Initiative

Begun in 1995, "the OASA/DCFS Initiative," modeled partially on Project SAFE, required OASA to invest in treatment services for women with children involved in the child welfare system. Funding, which providers say has been relatively stable, comes from general revenue dollars and the federal Substance Abuse Block Grant. The initiative originally focused on Cook County but was expanded statewide in 1998.

Treatment programs that received this funding were considered "initiative" providers, and they agreed to collaboration and reporting requirements. Out of about 150 state-funded treatment providers in Illinois, 32 are initiative providers. These 32 providers operate more than 70 treatment sites across the state.

Key facets of the initiative have included:

Interagency agreement.

An interagency agreement enumerates the broad responsibilities of each of the two departments and the funded providers participating in the Initiative. Each department has also issued written guidance, explaining what is expected of alcohol and drug treatment providers who participate and public and private child welfare agency caseworkers. The agreement also establishes screening tools, joint client consent forms, and referral and reporting documents.

Advisory committee structure.

An advisory committee, made up of stakeholders from both systems and the juvenile court, meets quarterly. The Advisory Committee is co-chaired by the OASA Associate Director and DCFS Deputy Director. Four subcommittees also meet periodically between full committee meetings. Subcommittees focus on best practices, training, research and development, and the DCFS Title IV-E Waiver project on enhanced services for substance-affected families.

Under the five-year waiver, begun in 2000, DCFS is providing enhanced alcohol and drug outreach, case management, and other support services to child welfare-involved families in Cook County. The goals of the waiver program are to: increase the rate of reunification, reduce the length of stay in foster care, reduce abuse and neglect allegations, and increase successful treatment

completion rates. The effects will be evaluated by the Children and Family Research Center at the University of Illinois.

Progress matrix.

A matrix was developed by the DCFS Inspector General's office to guide child welfare workers as they assessed the progress over time of a parent in treatment. The matrix, which DCFS staff and providers say has been extremely useful, serves many purposes, including:

- Giving caseworkers a visual tool when working with parents to set goals.
- Helping child welfare supervisors structure supervision of caseworkers.
- Providing a structure for collaboration service planning for the child welfare and alcohol and drug treatment systems.
- Helping judges and attorneys structure questions for in-court testimony and reach decisions and make findings about the level of progress during court reviews.

The matrix helps measure progress in a variety of areas (treatment, recovery support systems, abstinence, parental skills) by providing benchmarks for different levels of progress (poor, some, moderate, and substantial progress) in a variety of areas (including treatment, recovery support, and parental skills) at different time points (0-3 months, 3-6 months, and 9-12 months). According to providers and DCFS staff, the matrix creates a common language that can improve communication between the two systems.

Cross-training.

The training subcommittee has focused on identifying training needs in OASA, among treatment providers, and in the child welfare system. The subcommittee has helped ensure the provision of multimedia and written training to front-line child welfare workers about the basics of addiction and addiction treatment, including screening.

All newly hired DCFS workers receive the training as part of their orientation into the system. The goal of the training is not to transform caseworkers into addiction experts, but to give them knowledge that will help them determine when an assessment might be needed and what referral sources are available.

The subcommittee is currently working on developing training specifically on methadone services as a result of recognizing misconceptions and misunderstandings about it in the child welfare system and the courts.

Protocols for screening and referral for assessment and treatment.

Under the initiative, DCFS workers are expected to screen parents for alcohol and drug problems within 30 days of the case opening. Workers use a three-page standardized substance abuse screening tool that requires information to be collected through both observation and interview.

Individuals are referred to an OASA/DCFS Initiative provider for further assessment, if

it is deemed necessary or appropriate. Workers are expected to refer clients for an assessment within 30 days of case opening. They either enter treatment, or the assessment provider reports back to DCFS that they do not need treatment.

Instituting systems for client tracking and cross-system information exchange.

DCFS, OASA, and treatment providers have worked to collaborate and exchange appropriate information about how parents are doing in treatment. But they have also been clear about whose responsibility it is to collect the needed information, such as about the environment, the parent's emotional and physical state, and whether the parent has a new partner.

Main Effects of ASFA

The number of children in foster care in Illinois has decreased by almost half since FY 97, from a 12-year high of 51,331 in FY 97 to 23,382 children in FY 02. In FY 02, 3,339 foster children were placed into adoptive homes, 1,081 children were placed into permanent homes through subsidized guardianship, and 2,740 children were reunified with their birth parents. In total, 7,160 children – or about one-third of all foster children in the state – were moved into permanency in FY 02.

According to DCFS staff, most clients receive family reunification services during the first 12 months of their case, unless family history (such as a child homicide) clearly contraindicates. In those cases, the focus is on expediting termination of parental rights. An 11-month progress review is built into the process, so both systems and clients will know where they stand before the 12-month time frame for determining whether to continue to work toward reunification or to start moving toward termination of parental rights.

DCFS staff say they have moved toward adoption more quickly in more cases, where previously children entered and stayed in the foster care system. While the goals of DCFS have included increasing reunification, the work with OASA and providers has also helped identify more quickly cases where that will not be possible.

According to DCFS staff, court-involved cases have become more complicated and difficult, partly because of earlier assessment for alcohol and drug problems. The agency has also identified the need to provide training to public defenders, private attorneys, and guardians ad litem to prevent them from creating obstacles for assessment.

According to DCFS and providers, in addition to state-level collaboration, local and front-line collaboration has grown as a result of the initiative and ASFA. Workers from both systems have developed relationships and learned to understand and support one another.

Continuing Challenges

DCFS staff and treatment providers identified several continuing challenges and needs. They include:

- Collaboration and communication with other systems.

Clients enter alcohol and drug treatment from many different systems, including the criminal justice system or hospital- or self-

referral. Of particular concern are the TANF and the parole/probation systems and the differing requirements and accountability they impose. DCFS is working to improve communication with all of the systems that clients are involved with about their child welfare and treatment requirements.

- Staff turnover.

Turnover is one of the biggest problems facing the child welfare and treatment systems. This turnover means that cross-training has to be ongoing. DCFS staff and providers report that cross-training is an ongoing process that has been successful.

- Co-occurring mental health problems among clients.

A big challenge has been identifying women who are also suffering from severe depression, post-traumatic stress disorder (PTSD), and other mental health problems in addition to alcohol and drug problems. According to DCFS, trying to identify when women have co-occurring mental health and alcohol and drug problems has required additional staff training and additional assessments.

For providers, it can also require different staffing patterns, such as hiring on-site psychiatrists, and resources for psychotropic medications and medications monitoring. An added complexity is ensuring access to medication for women who are leaving treatment.

A statewide consortium – made up of mental health and alcohol and drug agencies and providers – is currently involved in providing cross-training and designing treatment protocols for this population. But resources are limited.

- Treatment capacity and resources for services.

Overall, the system does not have enough capacity, particularly for clients with co-occurring mental health and alcohol and drug problems and for methadone. In some places, however, full treatment capacity is not being used. Resources and capacity have become more complicated as clients are presenting with more problems and involved in more systems. In addition, front-line workers feel constrained and limited by their lack of awareness of resources that their clients need.

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Appendix A
Model for Addressing the Needs of Addicted Parents Involved in the Child Welfare System (Full Version)

Collaborative Local Planning and Monitoring

Representatives of the state/county alcohol and drug agency, the state/county child welfare agency, and addiction treatment programs should collaborate to design policies and practices for addressing the needs of parents involved in the child welfare system who have alcohol and drug problems within the framework of ASFA and with the goal of reunification. Representatives of other systems – such as family drug courts, where they exist, other courts, and the Temporary Assistance for Needed Families (TANF) agency – should also be included where appropriate.

For state and county agencies without a history of collaboration, a good starting point is meeting over a period of time in a structured way to share information about how each system works, its statutory responsibilities and how they are implemented, and its expectations both of clients and in partnering. State/local needs and requirements should determine whether the group should be formal (for example, whether legislative authority or a Memorandum of Understanding is needed) or informal.

Key policies and practices to develop jointly should include: screening and assessment, referral to treatment, monitoring of treatment (including protocols for sharing of appropriate information and protection of client confidentiality), treatment placement criteria/standards, provision of continuing care, and protocols for handling decisions about relapse and its effects on child safety – within ASFA's time limits. The group should also identify any statutory or regulatory barriers to these policies and the steps necessary to overcome them.

Such in-depth collaboration should help build and sustain interagency relationships, including developing a common language and shared goals and benchmarks (like a progress matrix developed in Cook County, Illinois) for agencies and providers involved.

Identification of Funding Available for Needed Services

Each system should identify funding streams available to support needed services, including basic treatment services, continuing care/relapse prevention, and support services, such as safe and sober

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housing and job training. Increased investment may be needed to build capacity for gender-specific services (including services that provide child care and other parental supports), as well as provider infrastructure. Attention should also be paid to identifying funding for meeting the needs of individuals who have other co-occurring disorders, such as mental illness, HIV/AIDS, and tuberculosis.

Potential sources of funding include: Medicaid, TANF, IV-E funds, Substance Abuse Block Grant, state or local levy, or general revenue funds. Matching requirements and other restrictions, flexibility and eligibility issues, and availability should be analyzed.

Information Sharing and Continuing Communication and Collaboration

Information that the child welfare agency should share with the treatment program at the point of referral should include:

- Basic demographic data, including insurance status.
- Reason for referral. Reasons could include: specific relevant risk factors identified, court order, known facts (such as DUI or DWI conviction), or failure at a work site. The agency should also tell the provider whether the client seems motivated for treatment.
- Safety risks for children, including how the parent's or caregiver's alcohol and drug use affects the children, how it impairs their ability to care safely for the children, and whether the children have any special needs.
- Placement of the children, such as at home, with a relative, or in foster care.
- Time frame/permanency consideration. This includes information about the legal time frame for reunification and permanency decisions.

Agencies should also plan for information sharing during treatment, including:

- Development of a standardized, written consent form to be signed by the client and other mechanisms for communication in compliance with federal regulations on alcohol and drug treatment client confidentiality (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (45 CFR Parts 160 & 164) taking into account the multiple agencies that may be sharing the information, including child welfare, treatment, criminal/juvenile justice, and TANF.
- Identification of automatic triggers for information sharing, at such points as assessment, drug testing, progress reports of ongoing treatment, after care, no shows, and leaving treatment.
- Planning for participation in court proceedings. Each system should maintain areas of expertise. For example, the CPS worker must be responsible for providing information and recommendations about the risk to the child, while the alcohol and drug treatment provider is responsible for reporting on

treatment progress and the potential for treatment success within the applicable legal permanency time frame.

Development of Criteria for Assessments

Agencies should agree on any standard instruments, methods, or expected elements of the assessment process. Generally, these elements include:

- Identification of the agency responsible for funding and conducting drug testing, if any is required under the policy.
- Information about history of alcohol and drug use and sobriety, including criminal background information, driving record related to drinking or drug use, and known past participation treatment.
- Self-report about whether the parent/care giver believes he or she has a problem.
- Recommendations for treatment, based on agreed upon patient placement criteria.
- Information from family members, when possible and indicated. Collateral information from family members is key for the child welfare system to provide to the treatment provider because treatment providers do not usually interview family members.

Cross-Training

Staff at all levels of the child welfare and alcohol and drug system should receive thorough training about their new responsibilities and the work and responsibilities of their partners. Child welfare staff expected to screen clients for alcohol and drug problems should receive adequate training to do so. Provision of training should be continuous, so that both existing staff and new hires can benefit.

Evaluation of Partnership, Policies, and Practices

The agencies should agree on how to evaluate the structure of their partnership, policies and practices adopted, and their effects on the agencies themselves, providers, and clients, including process and outcome data to be collected.

Appendix B
Cross-Site Questionnaire: Local Treatment Providers/Treatment System

1. What kinds of alcohol and drug treatment services does your program provide? What other services, if any, are available to clients? To what other services do you refer clients? Can clients bring their children into treatment with them?

2. What are your main sources of revenue? How have they increased or decreased in the last several years, if they have changed at all?

3. What barriers to treatment do your clients routinely face, including financial barriers? What barriers to care do their children face?

4. What policies has the state adopted to implement ASFA? How familiar are you with the provisions of the state's ASFA policies? Did you receive information or training about them from the state? What do you think of these policies? Knowing your clients and their needs, do these policies seem like the right approach?

5. Do you have a sense of how these policies are affecting your clients? (Probe about ASFA-related treatment drop-out rates.)

6. Have you found your clients' child welfare caseworkers knowledgeable about addiction and how to handle it? Have you found that caseworkers are willing to address addiction directly? If not, do you have a sense of what is in the way?

7. Were treatment providers involved in the design and implementation of the ASFA policies? If so, how? If not, what do you think were the barriers to participation?

8. Have referrals from the child welfare system increased, decreased, or stayed the same since the implementation of ASFA?

9. Do you receive any funding from the child welfare system to provide treatment or other services to these families? What restrictions affect what this funding can pay for?

10. If so, how did the state or county make the decision to invest child welfare funds in treatment? Did your program have any role in the designing and advocating the change?

11. How would you characterize your relationship with the state child welfare agency? Has the relationship changed? If so, how? If so, why do you think so?

12. How would you describe your relationship with the state alcohol and drug agency? Has it changed in the last few years? If so, how? If so, why do you think so?

13. What changes in child welfare policy would you advocate to improve the implementation of ASFA for your clients and their children?

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Appendix B

Cross-Site Questionnaire

State/Local Child Welfare Agency

1. What are the trends in the State/county child welfare caseload? What is driving those trends?

2. Do you have state or local data about the prevalence of alcohol and drug problems among families involved in the child welfare system?

3. What policies has the state/county adopted to implement ASFA? For example, how has the State defined "reasonable efforts"?

4. What efforts has the state/county taken to educate caseworkers about the changes? Have caseworkers received any training about addiction, how to recognize it, or how best to handle it? How have caseworkers responded?

5. What other State/local agencies are invoked in ASFA implementation? Did the state/county engage groups outside of government – such as treatment providers – in decisions around implementation? Why or why not?

6. Does the state invest child welfare funding in alcohol and drug treatment services? If so, how is the money allocated to treatment providers? How were providers chosen? Are there restrictions about what the funding can pay for?

7. If the State/county has invested child welfare funds in treatment, where did support come from for such an initiative? Where did opposition come from? What obstacles, if any, did you encounter between the idea to make these changes and their implementation?

8. What data, if any, were generated to support changes? Were the data influential? If not, why do you think they were not? What was influential?

9. What, if any, monitoring has taken place or continues to take place to measure changes in utilization? Are data being collected to measure the impact of these policy changes? Can you document that services are reaching those who need them?

10. Describe your relationship with the state alcohol and drug agency. Had you collaborated with the State alcohol and drug agency on any previous policy initiatives?

11. Describe your relationship with local alcohol and drug treatment providers. How has it changed since the implementation of ASFA?

12. What special needs do these children have? What are the barriers to meeting these needs?

13. Are many of them involved in the TANF system, regardless of whether their mother has custody of them? How is that affecting the rest of the family?

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Appendix B
Cross-Site Questionnaire: Judicial System

1. What policies has the State adopted to implement ASFA? For example, how has the State defined "reasonable efforts"? How were you informed about the changes? Do they seem to you like the right approach?

2. How are the courts handling ASFA cases? How is "the clock" being handled by the courts? In other words, how are you defining when a child has been in foster care for 15 out of the last 22 months?

3. What are the trends in out-of-home placements? Have they increased, decreased, or not changed? Do you think any changes are related to ASFA implementation?

4. What are the trends in terminations of parental rights? Have they increased, decreased, or seen no change? Do you think changes are related to ASFA implementation?

5. What changes, if any, have you seen in the children? Are their cases more severe? Are their needs more pronounced?

6. What kind of discretion do you have in adjudicating ASFA cases? Do you think you need more or less discretion, or is your discretion about right?

7. Do adequate treatment resources exist in the community to address alcohol and drug problems in the child welfare system? Are these resources appropriate to the population being served?

8. Are there enough individuals, couples, and families available to adopt children whose parents have lost their parental rights as a result of ASFA? Has availability increased, decreased, or stayed the same since the implementation of ASFA?

9. Are the courts monitoring changes in caseloads related to ASFA implementation? If so, how?

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